IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 25, 2008

Michael Dempsey
Family Home Health
2950 East Magic View Drive #192
Meridian, Idaho 83642

Dear Mr. Dempsey:

This is to advise you of the findings of the Medicare survey at Family Home Health which was concluded on February 20, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 7, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

Sylvia Creswell for

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137079	A. BUILDING _____ B. WING _____	02/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HOME HEALTH	2950 EAST MAGIC VIEW DR STE 192 MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification and complaint survey of your agency. Surveyors conducting the review were: Patrick Hendrickson, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Acronyms used in this report: HHA = Home Health Agency L = Liter RN = Registered Nurse SOC = Start of Care	G 000	RECEIVED MAR 05 2008 FACILITY STANDARDS	
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on staff interview and patient record review, it was determined the agency failed to document the existence of a complaint and the resolution of a complaint made by a patient's family member for 1 of 1 patient (patient #14) whose record showed such complaints. Findings include: * Patient #14 was an 85 year old female whose	G 107	(See attached)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

K. D. | Administrator | 3/3/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 107	Continued From page 1 SOC was 12/08/07. The patient was discharged from services on 1/29/08. The patient's primary admission diagnosis was decubitus ulcers. A Communication Note in the patient record, dated 12/15/07, stated that the patient's nephew called the on-call nurse with the complaint that the patient had not received oxygen that had been ordered by her physician. While the situation was remedied by the on call nurse, a formal complaint and resolution was not found in the agencies complaint log. On the patient's OASIS discharge assessment, dated 1/29/08, a note was written by the discharging R.N. stating that "... Caregiver has been unhappy with scheduling of all discipline visits...". There was no formal complaint and resolution found in the agency's complaint log referencing this complaint. On 2/19/08 at 2:57 PM, the Director of Nursing stated that she did receive the complaint pertaining to the delay in oxygen delivery to the patient. She stated that she apologized to the caregiver by telephone, replaced the R.N. with another Case Manager and counselled the R.N. She also stated that she did not document the complaint or the agency's resolution.	G 107		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, it was determined the HHA failed to	G 165	See attached	

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G 165	Continued From page 2 ensure that a patient's oxygen treatment was administered by agency staff as ordered by the physician in a timely manner for 1 of 19 patients whose records were reviewed (#14). The findings include: * Patient #14 was an 85 year old female whose SOC was 12/08/07. The patient was discharged from services on 1/29/08. The patient's admission diagnosis included decubitus ulcers. The patient's SOC assessment, stated on 12/08/07 the patient's pulse oxygen saturation was 83%, (Normal is greater than or equal to 93%). The patient's record contained orders, dated and faxed to the agency on 12/10/07 at 2:37 PM. The orders requested a chest x-ray, blood laboratory tests and continous oxygen treatment per nasal cannula at 2L/min. The chest X-ray was obtained on 12/11/07 un-timed and the results were sent to the agency on 12/11/07 at 3:17 PM. The chest X-ray results showed that the patient had left lower lobe pneumonia, cardiomegaly and chronic obstructive pulmonary disease. The patient's labs were drawn on 12/12/07 at 12:12 PM and were reported to the agency on 12/13/07 at 8:49 AM. The agency received further orders on 12/12/07 for the patient to start Levaquin 500 mg once a day to treat the patient's pneumonia. A nursing note dated 12/12/07 at 10:45 AM, documented the patients pulse oxygen saturation at that time was 80% and the patient was not utilizing oxygen therapy at that time. A second nursing note dated 12/14/07 at 10:55 AM, documented the patient's pulse oxygen saturation was 84% and the patient was not utilizing oxygen therapy at that time. The record contained no documented evidence that the patient was started on oxygen at 2L/min per nasal cannula until 12/15/07, five days after the original	G 165		

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G 165	Continued From page 3 orders. A "Disposition Communication Note" dated 12/15/07 at 9:40 AM by the on call nurse stated, patient's nephew "[name] called, irate stating 'We need oxygen for [patients name]'...I called in and faxed order to [business name] at 1230 12/15/07 and asked them to deliver home O2 today." On 2/19/08 at 1:45 PM, an employee who worked at the business that delivers oxygen and oxygen equipment to residential homes confirmed that business did not deliver oxygen to the patient's house until 12/15/07. On 2/19/08 2:45 PM, the Director of Nursing Services reviewed the record and stated that she was aware about the delay of the patient's oxygen. However, she could not give an explanation as to why it happened. On 2/20/08 at 8:10 AM, the nurse who was following the patient from 12/10 to 12/14/07 stated, "who ever takes the orders off the fax should read them" and stated he did not see the orders in the mail box until 12/14/07. When asked why he had ordered a chest x-ray on 12/11/07 and drew labs on 12/12/07 when he alleged that he had not seen the orders until 12/14/07 his reply was "I don't know, I don't remember every detail."	G 165		

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N 026	03.07020. ADMIN. GOV. BODY N026 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint. This Rule is not met as evidenced by: Refer to Federal deficiency G 107, as it relates to the failure of the agency to document the the investigation and resolution of a complaint.	N 026	See attached RECEIVED MAR 05 2008 FACILITY STANDARDS	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by:	N 173	See attached	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/3/08

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N 173	Continued From page 1 Refer to Federal deficiency G 165, as it relates to the failure of the agency to ensure that a patient's oxygen treatment was administered by agency staff as ordered by the physician in a timely manner.	N 173		

FAMILY HOME HEALTH
PLAN OF CORRECTION
(SURVEY COMPLETED 022008)
PREPARED BY:
Carrie Birch, RN, Director of Clinical Services

G107: 484.10 (b)(5) Exercise of Rights and Respect For Property and Person
N026: 03.07020 Admin. Gov. Body

Deficiency: Agency failed to document the existence of a complaint and the resolution of a complaint made by a patient's family member.

Plan of Correction:

- Agency staff and contractors will be in-serviced of need to report any and all patient/caregiver complaints to Director of Clinical Services.
- DCS will contact the complainant by telephone to obtain details of complaint.
- The complaint will be documented in the agency ***Complaint Log*** and an investigation of the complaint will ensue.
- Upon completion of the investigation, the Director of Clinical Services will provide the complainant, in writing, with the resolution of the complaint.

Person Responsible for Implementing/Monitoring Changes/Ensure Compliance:

- Director of Clinical Services

Date of Deficiency Correction:

- 031108 and monitor on an ongoing basis

G165: 484.18(c) Conformance With Physician Orders
N173: 03.07030.07 Plan of Care

Deficiency: Agency failed to ensure that patient's medication/treatment was administered by agency staff, as ordered by the physician, in a timely manner.

Plan of Correction:

- All orders (supplemental and telephone) are to be submitted to the Director of Clinical Services for review.
- A copy of supplemental and/or telephone orders requesting services, medications or treatments, reviewed by DCS, will be provided to the Intake Coordinator who will keep a "tickler file" of outstanding orders. If the physician has not responded within 24 hours, the Intake Coordinator will make personal contact with the author of the order with instructions to personally contact the physician.
- Agency staff and contractors will be in-serviced on the urgency of contacting the patient's physician with untoward/emergent issues identified during a home visit. If the physician cannot be reached and/or does not respond, the patient/caregiver will be instructed by agency staff to go to the Emergency Department for evaluation of these issues.

Person Responsible for Implementing/Monitoring Changes/Ensure Compliance:

- Director of Clinical Services

Date of Deficiency Correction:

- 031108 and monitor on and ongoing basis

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March 7, 2008

Michael Dempsey
Family Home Health
2950 Magic View Drive #192
Meridian, Idaho 83642

Provider #137079

Dear Mr. Dempsey:

On **February 20, 2008**, a Complaint Investigation was conducted at Family Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003388

Allegation #1: The agency's nursing staff delayed initiating physicians orders.

Findings: An unannounced survey was made to the home health agency on 2/14/08. Patients and nursing staff were interviewed along with review of 19 patient medical records.

Eighteen of 19 patient records contained adequate staff response to physicians' orders. One patient's record contained a start of care (SOC) assessment that was done on 12/08/07. The assessment stated the patient's pulse oxygen saturation was 83%, (Normal is greater than or equal to 93%) on that day. The patient's record also contained orders, dated and faxed to the agency on 12/10/07 at 2:37 PM. The orders requested a chest x-ray, blood laboratory tests and continous oxygen treatment per nasal cannula at 2L/min. The chest X-ray was obtained on 12/11/07 un-timed and the results were sent to the agency on 12/11/07 at 3:17 PM. The patient's labs were drawn on 12/12/07 at 12:12 PM and were reported to the agency on 12/13/07 at 8:49 AM. A nursing note dated 12/12/07 at 10:45 AM, documented the patient's pulse oxygen saturation at that time was 80% and the patient was not utilizing oxygen therapy at that time. A second nursing note dated 12/14/07 at 10:55 AM, documented the patient's pulse oxygen saturation was 84% and the patient was not utilizing oxygen therapy at that time. The record contained no documented evidence that the patient was started on oxygen at 2L/min per nasal cannula until 12/15/07, five days after the original order.

On 2/19/08 at 1:45 PM, an employee who worked at the business that delivers oxygen and oxygen equipment to residential homes confirmed that business did not deliver oxygen to the patient's house until 12/15/07.

On 2/19/08 2:45 PM, the Director of Nursing Services reviewed the record and stated that she was aware about the delay of the patient's oxygen.

Deficiencies were cited at 42 CFR 484.18 (c) Standard: Conformance With Physician Orders, for the failure of the agency to ensure that a patients oxygen treatment was administered by agency staff as ordered by the physician in a timely manner.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: Physicial Therapy services were not provided as ordered by patients' physicians.

Findings: Four of 4 current patients that had physical therapy services stated they had been receiving their therapy as ordered by their physician. Twelve of 12 patient records that were reviewed for physical therapy services contained documented evidence that the services were provided as ordered. One patient's record documented the physician had ordered physical therapy services for his patient 2 times a week. The physical therapist saw the patient on 12/21/07, 12/28/07, 1/4/08, 1/5/08, 1/11/08, 1/13/08, 1/16/08, 1/21/08, 1/26/08, 1/28/08 and the patient was discharged on 1/29/08. The record contained missed visit notes that were faxed to the physician for 12/17/07, 12/27/07 and 1/8/08. Each one of these 3 notes stated "Unable to contact client/No answer to locked door." They further stated that the therapist had also called the home number and no one answered the phone.

Although it may have occurred, it could not be determined during the complaint investigation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The agency sent staff to patients' homes without regards to the families or patients' schedules.

Findings: Seven of 7 current patients stated that the agency sent staff to their homes per their individual schedule. Twelve patient records were reviewed. One patient's record documented that during the first week of services were before 2:00 PM. By the second week of service all disciplines arrived at the patient's home after 4:00 PM and as late as 6:00 PM.

On 2/19/08 2:45 PM, the Director of Nursing Services stated that the agency tries to adjust to patient schedules as best as possible depending on staff and the patients' needs.

Although it may have occurred, it could not be determined during the investigation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The agency did not respond to patients' or families complaints.

Findings: Seven of 7 patients who were interviewed stated they had not voiced any complaints to staff. Eighteen of 19 patient records did not contain documented evidence that family or patients had voiced concerns regarding care issues. However, one patient's record contained a "Communication Note", dated 12/15/07, that stated the patient's nephew called the on-call nurse with the complaint that the patient had not received oxygen that had been ordered by her physician. While the situation was remedied by the on call nurse, a formal complaint and resolution was not found in the agencies complaint log. Further, the patient's discharge assessment, dated 1/29/08, contained a note that was written by the discharging R.N. stating "... Caregiver has been unhappy with scheduling of all discipline visits...". There was no formal complaint and resolution found in the agency's complaint log referencing this complaint.

On 2/19/08 at 2:57 PM, the Director of Nursing stated that she did receive the complaint pertaining to the delay in oxygen delivery to the patient. She stated that she apologized to the caregiver by telephone, replaced the R.N. with another Case Manager and counseled the R.N. She also stated that she did not document the complaint or the agency's resolution.

Deficiencies were cited at 42 CFR 484.10 (c)Standard: Patient Rights, for the failure of the agency to ensure to document the existence of a complaint and the resolution of a complaint made by a patient's family member.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #5: The agency discharged a patient without offering the patient a referral to other agencies.

Findings: One patient's record out of 19 revealed an 85 year old female whose SOC was 12/08/07. The patient was discharged from services on 1/29/08.

On 2/19/08 at 2:57 PM, the Director of Nursing stated that the patient's family was dissatisfied with their services and choose to receive services from another agency. She said that she was told by the family member that they had obtained another agency. However, when she tried to send the patient's medical record to the agency they stated they had not heard of that patient. She said she had heard nothing since then.

While the event occurred, the facility was not cited as there are no Federal or State regulations governing agencies in their practices and decisions regarding providing patients with referrals to other agencies after they have been discharged from services.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw